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Persistent and Pervasive Problems at the Washington, DC, VA Medical Center Placed Patients and Assets at Unnecessary Risk

WASHINGTON – The VA Office of Inspector General (OIG) issued today its report on *Critical Deficiencies at the Washington DC VA Medical Center*. The report details how leaders at the medical center and in VA regional and national oversight positions had repeatedly been made aware of—and failed to remediate—long-standing problems with core hospital services that affect the delivery of quality patient care. The inspection report finds these problems included deficiencies in sterilizing instruments, getting supplies and equipment to patient care areas when needed, accounting for millions of dollars in inventory, promptly ordering prosthetic devices, and managing assets.

The inspection began in March 2017 after receiving a confidential complaint and sparked an *Interim Report* on April 12, 2017, in which the OIG called for immediate action. The inspection continued and was expanded to closely examine four areas of concern: (1) risk of harm to patients, (2) hospital service deficiencies affecting patient care, (3) lack of financial/asset controls, and (4) failures in leadership.

"Failed leadership at multiple levels within VA put patients and assets at the DC VA Medical Center at unnecessary risk and resulted in a breakdown of core services," said Inspector General Michael J. Missal. "It created a climate of complacency that allowed these conditions to exist for years. That there was no finding of patient harm was largely due to the efforts of many dedicated healthcare providers that overcame service deficiencies to ensure patients received needed care."

Key deficiencies identified in the report include the following:

- Lack of an accurate inventory leading to supply shortages that affected patient care
- Ineffective sterile processing causing instruments to be unavailable when needed for procedures—resulting in delays and cancellations of procedures, avoidable hospitalizations, and instances of prolonged or unnecessary anesthesia
- Failed efforts to accurately and consistently track and trend patient safety events
- Pervasive staffing issues across key departments such as logistics and sterile processing

- More than 10,000 open and pending prosthetic and sensory aid requests as of March 2017, with at least one veteran waiting more than a year for a prosthetic limb
- Underutilization of financial and inventory systems, with little documentation, that provided no assurances funds were appropriately expended
- Misuse of government credit cards to purchase approximately $92 million in supplies over two years, instead of using approved prime vendor contracts at more reasonable prices
- More than 500,000 noninventoried items accumulating in an inadequately secured warehouse, with many items stockpiled well beyond needed quantities, in unusable condition, or not meeting facility needs
- Documents with protected health information and personally identifiable information being stored within more than 1,300 unsecured boxes
- From 2013 to 2016, the Medical Center and the Veterans Integrated Service Network 5 leaders providing oversight received at least seven written reports detailing many of the same deficiencies the OIG identified in 2017

The OIG made 40 recommendations that were all accepted by VA. The VA's action plans and progress on implementing those recommendations are included in the report. The report states that the recommendations are meant to not only improve conditions at the DC VA Medical Center, but also to serve as a roadmap for other VA medical facilities. In addition, the findings are intended to help VA improve oversight by Veterans Integrated Service Networks and VA central offices by identifying opportunities to leverage data currently missing or siloed in various offices and departments.

The VA OIG conducts oversight of VA programs and operations, providing independent and objective reporting to VA and Congress in order to prevent and detect fraud, waste, and abuse, as well as enhance the VA's integrity, efficiency, and effectiveness. To report potential fraud, waste, mismanagement, or other abuse, contact the VA OIG Hotline at www.va.gov/oig/hotline/default.asp.